ALO--WWID-WIPP-2001-0001 Final Report

Occurrence Report

Waste Isolation Pilot Plant

(Name of Facility)

Nuclear Waste Operations/Disposal

(Facility Function)

Carlsbad Area Office Westinghouse Waste Isolation Div.

(Laboratory, Site, or Organization)

Name: XXXX
Title: ASSIST MGR **Telephone No.:** XXXX

(Facility Manager/Designee)

Name: XXXX
Title: ASSIST MGR **Telephone No.:** XXXX

(Originator/Transmitter)

Name: **Date:**

(Authorized Classifier (AC))

1. Occurrence Report Number: ALO--WWID-WIPP-2001-0001

Conduct of Operations Procedure Compliance

2. Report Type and Date: Final

	Date	Time
Notification:	01/17/2001	11:25 (MTZ)
Initial Update:	03/12/2001	05:47 (MTZ)
Latest Update:	03/12/2001	05:53 (MTZ)
Final:	04/19/2001	09:53 (MTZ)

3. Occurrence Category: Off-Normal

4. Number of Occurrences: 1 **Original OR:**

5. Division or Project: Waste Isolation Pilot Plant

6. Secretarial Office: EM - Environmental Management

7. System, Bldg., or Equipment: WIPP Facility

8. UCNI?: No

9. Plant Area: Facility

10. Date and Time Discovered: 01/03/2001 05:27 (MTZ)

11. Date and Time Categorized: 01/12/2001 13:30 (MTZ)

12. DOE Notification:

13. Other Notifications:

14. Subject or Title of Occurrence:

Conduct of Operations Procedure Compliance

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15. Nature of Occurrence:

10) Cross-Category Items

A. Collectively Significant Related Occurrences

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16. Description of Occurrence:

On January 3, 2001 at 0527 hours the Facility Roving Watch was in the process of tagging out a circuit breaker at Substation 3 (CB-11). The operator verified the breaker was open by visual inspection and by depressing the trip mechanism. The operator then proceeded to retrieve the "rack out tool" to place the breaker in the proper location. When the operator returned to the breaker the trip mechanism was depressed to utilize the rack out tool and place the breaker in the proper location. At that time the breaker opened and the operator immediately realized that the breaker he had tripped was the wrong breaker.

On January 8, 2001 at 0933 hours the CMRO was notified by a Radiological Control Technician that the dose rate meter being used for surveys on the shipment being processed had an expired calibration due date. The due date was January 6, 2001. The instrument with the past due calibration date was incorrectly used because a step in the operational checks was missed. Waste processing resumed at 1010 hours.

On January 9, 2001 at 0957 hours, the Central Monitoring Room Operator was notified by the Emergency Services Technician (EST) that the Dry Chemical System in the Underground had been inadvertently discharged. The EST was in the U/G performing and annual inspection on the fire alarm pull box stations. The EST notified the CMR of the inspection and proceeded to disconnect the actuators of the system as required by the preventive maintenance procedure. Prior to disconnecting the actuators the EST unlocked the fire panel to gain access to the acknowledge button. After the panel was unlocked the EST activated the pull station without disconnecting the actuators. The discharge impacted the immediate area only and no other work was in progress in the area. Access to the area was restored at 1045. A debriefing was conducted with the EST.

On 1/10/01 at approximately 1530 a Cognizant Engineer (CE) reviewed Radiation Work Permit (RWP) RWP-01-0018, Canberra CAM system replacement and testing, with the intent to enter and inspect the newly replaced portions of the Canberra CAM system in the CH Bay. The CE, who is Radiological Worker(RW)-I, noticed the minimum training requirement for the RWP was RW-II. He immediately questioned the Radiological Control Technician (RCT) about the training requirement. The RCT agreed that the minimum training requirement for the job should be RW-I and checked to see if any of the individuals currently signed on the RWP had entered the CH Bay RMA . According to the access control sheet four individuals had entered the RMA under the RWP earlier in the day. The RCT notified the OHP Manager who verified the level of training of the individuals. Three of the personnel were RW-I trained and the other person was RW-II trained.

On January 12, 2001 at 1110 hours the U/G Facility Operator inadvertently opened the wrong breaker in switching station #2. The operator was in the process of administering a tagout to support work activities. The tagout identified the breaker as CB-4 switching station 2 for 74-PPC10/2. The operator arrived at switching station 2 and proceeded to open the door to CB-5, power to Substation #3. The operator continued with the process and opened CB-5. Upon opening the breaker the operator immediately realized what had occurred and notified the CMR.

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17. Operating Conditions of Facility at Time of Occurrence:

Normal Operations

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18. Activity Category:

03 - Normal Operations

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19. Immediate Actions Taken and Results:

1) January 3rd, The operator immediately notified the CMRO and restored power in two minutes. The crew was briefed by the Crew Manager on the need for attention to detail. A briefing on the event was conducted with the operator.

2) January 8th, Waste handling was suspended until verification was performed with a verified and calibrated instrument containing a valid calibration due date. The readings taken with the new instrument read the same. The instrument with the passed due date on the calibration was taken out of service.

3) January 9th, the EST immediately notified the CMR of the event and had personnel remain clear of the area. The discharged material was collected and disposed of. The fuel stored in the station was removed from the Underground. A briefing was conducted with the EST.

4) January 10th, the RCT immediately notified the OHP Manager who verified the level of training of the individuals. Three of the individuals were RW-I trained and the other person was RW-II trained. The three personnel were briefed on RWP usage. The RWP was removed from the system and revised to include the proper training requirements, RW-I.

5) January 12th, The Underground operator immediately notified the CMR and began power restoration. The operator was briefed on the event and the consequences.

WID Operations Management conducted a standown on the morning of January 15, 2001 for all of the

Operations personnel. This was performed prior to personnel going to work in the field. The standown consisted of identification and discussion of recent events. Emphasis was placed on safety, personnel to take extra time to conduct their activities, and to report any issues or concerns.

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20. Direct Cause:

3) Personnel Error

A. Inattention to Detail

21. Contributing Cause(s):

22. Root Cause:

3) Personnel Error

A. Inattention to Detail

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23. Description of Cause:

After review of the individual events the root cause and direct cause are Inattention to Detail. The individuals involved all stated that they knew the requirements but at that moment they either missed the step of the procedure or didn't focus on what they were doing.

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24. Evaluation (by Facility Manager/Designee):

The events were reviewed for determination of cause. Inattention To Detail was the root cause and direct cause. Operations all hands meetings were held to enhance the conduct of operations awareness.

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25. Is Further Evaluation Required?: No

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26. Corrective Actions

(* = Date added/revised since final report was approved.)

1. Conduct a debriefing with the individuals involved in the events.

Target Completion Date: 03/09/2001	**Completion Date:** 01/12/2001

2. Complete the actions for Corrective Action Report FY2001-11, Facility Operations conduct of operations awareness.

Target Completion Date: 03/09/2001	**Completion Date:** 02/24/2001

3. Complete the Radiological Awareness Report 2001-01, Construction personnel attention to detail.

Target Completion Date: 03/09/2001	**Completion Date:** 01/16/2001

4. Conduct an Operations all hands meeting to discuss "Conduct of Operations" and attention to detail involving the events in January.

Target Completion Date: 01/15/2001	**Completion Date:** 01/15/2001

5.

Provide information about procedure compliance and attention to detail to all employees.	
Target Completion Date: 01/19/2001	**Completion Date:** 01/19/2001

27. Impact on Environment, Safety and Health:

NONE

28. Programmatic Impact:

NONE

29. Impact on Codes and Standards:

NONE

30. Lessons Learned:

During the Holidays and during time of Company transition it is important to keep the employees focused.

31. Similar Occurrence Report Numbers:

1. None

32. User-defined Field #1:

33. User-defined Field #2:

34. DOE Facility Representative Input:

The WIPP Facility Representative (FR) concurs with the M&OC's assessment of these cross-category occurrences, the immediate actions, and the corrective actions taken. Although none of these occurrences resulted in injury or system failure, collectively and the short period of time in which they occurred, all occurrence indicated a trend of personnel inattention to detail.

The WIPP FR attended and participated in as many safety stand down sessions on January 15, 2001 as practicable. The FR prensented summaries of occurrences that resulted in near-miss or injury accidents from complex experiences in recent months.

FR's presence and presnetations re-inforced the CBFO's conduct of operations expectations.
Entered by: XXXX Date: 04/19/2001

35. DOE Program Manager Input:

36. Approvals:

Approved by: XXXX Facility Manager/Designee
Date: 03/12/2001
Telephone No.: XXXX

Approved by: XXXX Facility Representative/Designee
Date: 04/19/2001
Telephone No.: **XXXX**

Approved by: Approval delegated to FR
Date: 04/19/2001
Telephone No.:
